



## Beauty, Hair & Nail Salons - Professional Liability Supplemental

Named Insured: _____ Location Address: # _____ City, State, Zip: _____ County: _____	<b>Producers Name &amp; Address / Contact</b>  _____ _____ _____
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# Barber _____	# Waxing Operator _____	If waxing, what % of Total operations _____%
# Estheticians _____	# Masseuse _____	If massages, include chiropractic methods? <input type="checkbox"/> YES <input type="checkbox"/> NO
# Manicurist _____	# Cosmetologist _____	Permanent Cosmetics? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, _____%

1. If such exist, are all license(s) acquired and in good standing with the governing regulatory authority?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Any product (manufactured sold or distributed) under the Insured's Label? If yes, please attach more information on each and all products under Insured own Label.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Any Piercing? If yes, where <input type="checkbox"/> Ears <input type="checkbox"/> Nose <input type="checkbox"/> Tongue <input type="checkbox"/> Body <input type="checkbox"/> Genitals (select all that apply)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Any ear Candling?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Any Electrolysis or Laser treatments? If yes, additional information will be required	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Any Tanning Beds? If Yes, complete Tanning Supplemental	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Any Dermabrasion (including Microdermabrasion)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Any weight loss or Diet Programs?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9. Any use of chemical peels? (including Glycolic Acid or similar chemicals)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
10. Any Botox Injections or any other medical procedures?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
11. Any Plastic Surgery (including wart or mole removal)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
12. Any Hair Treatments, Implants or Transplants?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
13. Any Eyelash Extensions? If yes, it is _____% of Total operations. Are all eyelash extension technicians certified	<input type="checkbox"/> YES <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> NO
14. Any Body wrapping? If yes, are all wraps organic? if no, please explain types used:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
15. Any micro blading? If yes, it is _____% of Total operations.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
16. Any claims in the last 3 years in regards to professional Services / liability? If yes, provide details:	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**FRAUD STATEMENT:** Any person who knowingly and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty.

**WARRANTIES:** I/we warrant that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the company evidence its acceptance of this application by issuance of a policy.

**SIGNING THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE**

Signature of Applicant X \_\_\_\_\_ Date: \_\_\_\_\_ (Owner, Officer or Partner)

Signature of Agent X \_\_\_\_\_ Date: \_\_\_\_\_ (Licensed Agent)